| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155789 | A. BUILDING 02 , 01<br>B. WING _____ | R<br>09/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGEWOOD HEALTH CAMPUS | 181 CAMPUS DR<br>LAWRENCEBURG, IN 47025 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS<br><br>A Post Survey Revisit (PSR) to the Comparative Federal Monitoring Survey conducted on 07/10/12 and a Quality Assurance Walk-thru survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 09/11/12<br><br>Facility Number: 012523<br>Provider Number: 155789<br>AIM Number: 201027870<br><br>Surveyor: Mark Bugni, Life Safety Code Specialist<br><br>At this PSR and Quality Assurance Walk-thru survey, Ridgewood Health Campus was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.<br><br>Ridgewood Health Campus consisted of two separate buildings: the Main Campus Building determined to be a one story building of Type V (111) construction and fully sprinklered and the Legacy Building, located to the southeast of the Main Campus building, a one story building of Type V (111) construction and fully sprinklered. Both facilities have a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 61 and had | {K 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|---|---|---|---|---|
| {K 000} | Continued From page 1<br>a census of 55 at the time of this visit.<br><br>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.<br><br>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/18/12. | {K 000} | | |